(13) (14) (14)

Nos. 93-1408, 93-1414, 93-1415

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, et al.,

Petitioners,

vs.

TRAVELERS INSURANCE CO., et al.,

Respondents.

(Caption Continued on Reverse Side of Cover)

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION, THE MARYLAND HOSPITAL ASSOCIATION, INC., AND THE MASSACHUSETTS HOSPITAL ASSOCIATION, INC. AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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MARIO CUOMO, GOVERNOR OF NEW YORK, et al.,

Petitioners,

vs.

TRAVELERS INSURANCE CO., et al.,

Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioner,

vs.

TRAVELERS INSURANCE CO., et al.,

Respondents.

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Interest of the Amici Curiae

Amici curiae the American Hospital Association ("AHA"), the Maryland Hospital Association, Inc., and the Massachusetts Hospital Association, Inc., respectfully submit this brief in support of the Petitioners. All parties have given written consent to the filing of this brief, and the letters so stating have been filed with the Clerk of the Court.

Founded in 1898, the AHA is the primary organization of hospitals in the United States. Its institutional members include approximately 80% of the nation's hospitals, and nearly 50,000 health care professionals hold individual membership.

The AHA's corporate mission is to promote the quality of American health care for all people through leadership and assistance to hospitals and other health care organizations. To fulfill this mission, the AHA regularly participates in the judicial and legislative arena to address important issues concerning federal and state health care reform in general and hospital regulation in particular. The Maryland Hospital Association and the Massachusetts Hospital Association are the leading organizations of hospitals in their respective states and are independent associations whose missions, goals, and concerns are allied with those of the AHA in this matter.

As leaders in the health care field, and as representatives of health care institutions whose continued survival and service to society depend on equitable regulation, apportionment, and reimbursement of necessary costs, amici are vitally concerned that states retain the flexibility to assure equal access to affordable high-quality health care, a goal that will be seriously undermined if the decision of the Second Circuit Court of Appeals is permitted to stand.

Introduction and Summary of Argument

In light of the recent failure to enact comprehensive federal health care reform legislation, and uncertainties as to the future of such federal initiatives, it is likely that the states will be the primary venue of continued reform efforts. New York State has

long been an innovative leader in attempting to provide affordable and quality health care to all of its residents.

States' efforts to implement comprehensive reform legislation, and their efforts to spread health care costs over the widest possible base, have been significantly frustrated by the breadth of ERISA's preemption provision. State laws that, for example, require employers to offer or pay for health benefits, or impose mandated benefits on self-funded plans, or directly tax plans or benefits, have all been held preempted.

The Court is not here called upon to read ERISA § 514(a) more narrowly than heretofore. But this appeal does seek to reverse a judicial extension of ERISA's preemptive sweep that erodes the states' remaining flexibility to regulate and equitably apportion the costs of hospital care among all payors without reference or regard to their status as ERISA plans. An affirmance of the decision below could well leave states essentially powerless to act in the health care field, a result that Congress could not conceivably have intended and is, indeed, directly contrary to its express intent.

In *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), New York's statutory hospital reimbursement system, which regulated the rates of all payors, was upheld against a claim of ERISA preemption. Expressly agreeing with *Rebaldo*'s analysis and reasoning, the Third Circuit likewise held that New Jersey's comprehensive reimbursement statutes were not preempted. *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Mem. Hosp.*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 and 114 S. Ct. 383 (1993). In the present case, the Second Circuit invalidated the challenged portions of New York's reimbursement statute and, in so doing, disagreed with *United Wire* and disavowed its prior reasoning in *Rebaldo*. 14 F.3d 708, 714, 719-20.

The Petitions for Certiorari herein stressed this conflict in the Circuit Courts and the national importance of the issue presented. That issue is whether states have the power, in

general, to set hospital rates for patients who happen to be ERISA plan participants. If all such state laws are preempted, it is unnecessary to reach the question whether the particular New York rate differentials invalidated below are lawful. It will, however, become necessary in the future for the courts to entertain innumerable ERISA challenges to a wide variety of state laws that indirectly affect plans simply because they potentially increase plans' costs of doing business or potentially decrease contributions to the plans.

We show below that a state's exercise of its inherent police powers to provide for the health and welfare of its citizens through the establishment of mandatory hospital rates is not preempted. First, the purpose of ERISA was not to regulate or preempt generally applicable state laws that affect the price of services to plan participants. Second, state hospital reimbursement systems that establish uniform rates are not superseded because (i) they do no more than substitute for the rights and obligations between patient and hospital that exist under common law; (ii) they do not impact upon ERISA plans other than in a tenuous and remote manner; and (iii) Congress has expressly encouraged states' efforts to control costs through the adoption of all-payor systems. Third, state reimbursement systems that produce disparate rates — such as those resulting from the differentials at issue — stand in no different position vis-à-vis ERISA preemption than uniform rate systems; neither relate to ERISA plans.

ARGUMENT

I

ERISA WAS NOT INTENDED TO PREEMPT STATE LAWS THAT AFFECT THE PRICE OF SERVICES TO PLAN PARTICIPANTS

Congress purposefully preempted broadly and this Court has insisted upon an expansive reading of the statutory text. In *District of Columbia v. Greater Washington Board of Trade*,

_ U.S. _ , 113 S. Ct. 580, 583 (1992), this Court summarized its prior description of the breadth of ERISA § 514(a) as follows:

> "We have repeatedly stated that a law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) 'if it has a connection with or reference to such a plan.' *Shaw*, *supra*, 463 U.S. at 97. *E.g.*, *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 829 (1988); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). This reading is true to the ordinary meaning of 'relate to,' see Black's Law Dictionary 1288 (6th ed. 1990), and thus gives effect to the 'deliberately expansive' language chosen by Congress. *Pilot Life*, *supra*, 481 U.S. at 46. See also *Morales v. Trans World Airlines, Inc.*, 504 U.S. _, _ (1992). Under § 514(a), ERISA pre-empts any state law that refers to or has a connection with covered benefit plans (and that does not fall within a § 514(b) exception) 'even if the law is not specifically designed to affect such plans, or the effect is only indirect,' *Ingersoll-Rand*, *supra*, 498 U.S. at 139, and even if the law is 'consistent with ERISA's substantive requirements,' *Metropolitan Life*, *supra*, 471 U.S. at 739.[1]

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[1] Pre-emption does not occur, however, if the state law has only a 'tenuous, remote, or peripheral' connection with covered plans. *Shaw*, 463 U.S., at 100, n.21, 103 S. Ct., at 2901, n.21, as is the case with many laws of general applicability, see *Mackey*, 486 U.S. at 830-838, and n.12, 108 S. Ct. at 2185-2190, and no. 12; cf. *Ingersoll-Rand*, 498 U.S. at 139, 111 S. Ct. at _."

In the present case, the Second Circuit has, in turn, given an expansive reading to this Court's pronouncements and has reached a conclusion that is not only unsupported by any holding or analysis of this Court, but produces a result that

Congress did not and, as a matter of "common sense," could not intend.

Because everything in the cosmos has, in some fashion, an indirect "connection with" everything else, including New York's differentials and ERISA plans, the question in each case is where the line should be drawn between those state actions that do or do not affect plans in too tenuous a "manner." It is the *nature* of the relationship that is significant. "[A]s in any preemption analysis, 'the purpose of Congress is the ultimate touchstone.' " *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985), quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978).

The purpose of ERISA is set forth in the statute itself:

> "[protecting] participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions and ready access to the Federal courts." [ERISA § 2(b), 29 U.S.C. § 1001(b).]

The object of protecting plan participants and the two means by which such protection is to be afforded — disclosure and fiduciary standards — are thus clear. But the fullest protection accorded to plan participants was not intended to confer on them some special advantage that nonparticipants do not enjoy in matters unrelated to the operation and administration of plans. Participants do not enjoy a "charmed existence that was never contemplated by Congress." *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 145 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989) (quoting *Rebaldo v. Cuomo*, *supra*).

This Court has not limited ERISA's preemptive sweep to state laws that relate to the subject matters regulated by ERISA: disclosure requirements or fiduciary standards. Also superseded are those laws that impair the efficient operation of plans

through burdensome and potentially conflicting administrative requirements. As explained in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987), a "patch-work scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them."

In precluding state interference with the operation and administration of plans, it is significant that ERISA itself imposes no substantive requirements on the content of plans. Employers are free to establish and fund such plans at any level, and plans are free to determine what type and extent of benefits they will provide to their participants. There are no maximum or minimum requirements.

Although ERISA § 514(a) preempts state laws only "insofar as" they relate to "plans," as opposed to benefits, and the statute does not mandate that any particular benefits must be offered, *Fort Halifax* also held that such laws are preempted "if they attempt to dictate what benefits shall be paid under a plan." *Id.* at 13 n.8. The Dissenting Opinion (*id.* at 26) did not disagree on this point. It relied on *Standard Oil Co. v. Agsalud*, 633 F.2d 760, 766 (9th Cir. 1980), *summarily aff'd*, 454 U.S. 801 (1981), as establishing that ERISA's concern was not only with uniformity in the administration of plans, but with "state statutes which require employers to provide particular employee benefits."

The New York laws at issue here neither interfere with plan administration nor require any particular benefits to be provided. They are yet a further step removed and affect only the *price* of hospital services to plan participants, which plans may choose to cover in whole or in part. Even if such laws may indirectly influence plans' decisions as to the level of benefits, they indirectly connect to plans in too tenuous a *manner* to result in preemption.

II

ERISA DOES NOT PREEMPT A STATE'S POWER TO ESTABLISH UNIFORM HOSPITAL RATES

Respondents assert (Br. in Opp. 1, 4, 13, 18) that the State's general power to set hospital rates is neither challenged nor undermined by the Second Circuit's decision herein.[1] This "concession" is made for two strategic purposes: First, they wish to retain all of the *benefits* of State limitations on hospital costs and rates while excising three provisions they find disagreeable — the differentials — from the extensive and unified regulatory scheme. More importantly, they seek to avoid an examination of the issue of ERISA's preemption of the State's rate-setting power because such an analysis dooms the challenge to the differentials. The very reasons *why* the rate-setting power is not preempted also demonstrate that when that power is exercised to produce disparate rates, the same result obtains.

Accordingly, in order to determine whether Congress intended to preempt the New York rate differentials here at issue, we first address (i) the rights and obligations of the

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[1] The District Court in the instant case observed in a *dictum* (813 F. Supp. 996, 1006) that preemption of the State's rate-setting power was a necessary consequence of its decision, but the Second Circuit did not expressly comment on that view. However, in *New England Health Care Union v. Mount Sinai Hosp.*, 846 F. Supp. 190 (D. Conn. 1994) (appeal docketed #94-7264), the District Court, adhering to its reading of the *Travelers* Decision, invalidated Connecticut's statutory Uncompensated Care Assessments (uniformly applicable to all nongovernmentally insured patients) to the extent that such patients were plan participants. As a result of that decision, Connecticut revised its statutes and the revisions are also being challenged as preempted. *Connecticut Hosp. Ass'n v. Pogue, et al.*, No. 3:94 CV 01224 (D. Conn.). In addition, other aspects of New York's reimbursement system are under attack on preemption grounds in *Connecticut Gen. Life Ins. Co., et al. v. Cuomo*, No. 93 Civ. 3648 (S.D.N.Y.) (balance billing law), and *Trustees Of & The Pension Hospitalization Benefit Plan, et al. v. Cuomo, et al.*, 92 Civ. 5589 (S.D.N.Y.) (bad debt and charity care funding provisions).

hospital and patient in the absence of any state regulation and (ii) state reimbursement systems that establish uniform rates. In Point III, we discuss reimbursement systems that, as in New York, produce disparate rates.

In New York, and nationally, patients typically agree to pay the hospitals' charges pursuant to an agreement that is express or implied by law. A hospital will usually accept assignment of a patient's health insurance, if any and from whatever source, but the patient remains personally liable for whatever portion of the hospital's bill remains unpaid by the insurer for any reason — be it a deductible, coinsurance requirement, denial of coverage, or an outright refusal to pay on any basis.

A state's common law will provide the hospital with a cause of action to recover against the patient for any unpaid portion of the bill. In the absence of state regulation of charges, the courts will enforce express contracts to pay the hospital's self-determined charges or allow recovery in *quantum meruit* for implied contracts. In the latter case, the courts will determine the "reasonable value" of services provided.[2]

Are these common law remedies unenforceable when the patient happens to be an ERISA participant? Does it make a difference that the state legislature establishes the hospital's charges rather than leaving that determination to the hospital itself, or for a judge to determine on an *ad hoc* basis?

A. ERISA Does Not Preempt Common Law Causes of Action Against Plan Participants

Although a state's common law is as fully within ERISA's preemptive reach as are its statutes,[3] there is no evidence that

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[2] *E.g.*, *McGuire v. Hughes*, 207 N.Y. 516, 519, 521, 101 N.E. 460 (1913); *Mount Sinai Hosp. v. Burns*, 138 Misc. 2d 381, 527 N.Y.S.2d 678 (N.Y. App. T. 1988); *see St. Peter's Hosp. v. Hall*, 102 Misc. 2d 73, 422 N.Y.S.2d 628 (N.Y. Sup. Ct. Albany Co. 1979) ("the charges are commensurate with those of other area hospitals").

[3] "State laws" preempted by ERISA include "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." *(Footnote continued)*

Congress intended to preempt state common law remedies against patients for breach of their implied or express agreements to pay the hospital simply because they happen to be plan participants. To the contrary, suits against ERISA *plans* themselves for "run-of-the-mill state-law claims such as unpaid rents, failure to pay creditors, or even torts" are not preempted. *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 833 (1988). It has been repeatedly held that when plans mistakenly confirm insurance coverage of a participant, and the hospital provides services in reliance thereon, the state law claim against the plan is not preempted. In *Hospice of Metro Denver, Inc. v. Group Health Ins.*, 944 F.2d 752 (10th Cir. 1991), the Court found that the impact on the plan of permitting recovery was too "tenuous, remote, or peripheral"; did not "affect the structure, the administration or type of benefits" of the plan (citing *Rebaldo*); did not threaten inconsistent State and local regulation; and the Congressional purpose in enacting ERISA was not transgressed. *Id.* at 754-55. "Preemption in this case would stretch the 'connected with or related to' standard too far." *Id.* at 756.[4]

If "run-of-the-mill" common law claims against *plans* for misrepresentations of coverage are not preempted, *a fortiori* the same result must apply when a plan *participant* is sued on his express or implied agreement to pay for hospital services. The rights and liabilities that inhere in the hospital-patient relationship exist independently of the patient's insurance, if any, or the patient's relationship, if any, with an ERISA plan.

ERISA § 514(c)(1), 29 U.S.C. § 1144(c)(1). Common law causes of action and remedies are thus included. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987).

[4] *Accord Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990); *Beth Israel Med. Ctr. v. Sciuto*, 1993 WL 258636 (S.D.N.Y. 1993); *Gaston Mem. Hosp. Home Health Serv. Inc. v. Bridgestone/Firestone, Inc.*, 830 F. Supp. 287 (W.D.N.C. 1993); *The Meadows v. Employers Health Ins.*, 826 F. Supp. 1225 (D. Ariz. 1993).

In *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 139-40 (1990), the Court reasoned that a state common law claim will be preempted if the "existence of a pension plan is a critical factor in determining liability"; if the "cause of action relates not merely to pension benefits, but to the essence of the pension *plan* itself "; and if "a plaintiff must plead, and the court must find, that an ERISA plan exists" to establish liability.

This analysis has consistently been applied to determine whether a state cause of action is preempted and is entirely in keeping with the plain meaning of the statute. State laws are preempted "*insofar as* they may now or hereafter relate to any employee benefit *plan*." ERISA § 514(a) (emphasis added).[5]

The hospital's common law cause of action has no "connection with" ERISA plans because the existence of any type of insurance, whether provided by a plan or otherwise, or its absence, is wholly irrelevant to the patient's individual obligation to pay. The hospital need *not* plead and the court need

[5] *See, e.g., Fort Halifax Co. v. Coyne, supra*, 482 U.S. at 23 (state severance payment law did not speak to *plans* and was not preempted); *Diduck v. Kaszycki & Sons Contractors, Inc.*, 974 F.2d 270, 287-88 (2d Cir. 1992) (fraud claim preempted because it concerns the conduct of a fiduciary and third party "in relation to the plan. . . . A state common law action which merely amounts to an alternative theory of recovery for conduct actionable under ERISA is preempted"); *Perkins v. Time Ins. Co.*, 898 F.2d 470 (5th Cir. 1990) (fraud claim against insurance agent not preempted because he was not an ERISA entity); *Monarch Cement Co. v. Lone Star Industries*, 982 F.2d 1448, 1453 (10th Cir. 1992) (contract claim not preempted because defendant, who agreed to fund pension plan, was liable as a seller of a business rather than a principal ERISA entity); *Compare Sanson v. General Motors Corp.*, 966 F.2d 618, 621 (11th Cir. 1992), *cert. denied*, _U.S._ , 113 S. Ct. 1578 (1993) (claim of fraudulently inducing employees to resign so as to forego retirement benefits preempted because existence of a plan was "critical" to claim) *with Forbus v. Sears Roebuck & Co.*, 30 F.3d 1402, 1406-07 (11th Cir. 1994) (misrepresentation claim concerning elimination of jobs, not plan benefits, not preempted; state fraud claim functions irrespective of an ERISA plan and "it would defy common sense to allow ERISA to preempt").

not find that an ERISA plan exists to establish liability. The patient is being sued in his or her capacity as a patient who has agreed to pay, not as a plan participant.

Preemption of state common law causes of action to enforce express or implied contracts would confer a "charmed existence" on plan participants (*Rebaldo* at 139) and lead to absurd results that Congress could never have intended. If a hospital simply refused to provide care to ERISA plan participants unless payment were received *in advance*, there would be no state law to apply or preempt. But requiring such "up front" payment "does not serve, but rather defeats, the purpose of Congress in enacting ERISA." *Memorial Hosp. Sys. v. Northbrook Life Ins. Co., supra*, 904 F.2d at 247; *see Beth Israel Med. Ctr. v. Sciuto, supra*, 1993 WL 258636 at *4; *Hospice of Metro Denver, Inc. v. Group Health Ins., supra*, 944 F.2d at 754-56.

Accordingly, the hospital's common law right to collect its charges from a patient subsists notwithstanding the patient's status as a plan participant and notwithstanding a plan's decision to indemnify the patient for all or part of his liability to the hospital.[6] The same is equally true when the hospital's charges are determined by a state.

B. State Rate-Setting

Codifying the common law, a state statute could simply provide that, "in the absence of an express contract, patients are liable for the reasonable value of the services provided." There can be no difference, for preemption purposes, between the

[6] In *New England Health Care Employees Union v. Mount Sinai Hosp., supra*, the District Court, on the basis of the Second Circuit's decision here, not only invalidated the State's Uncompensated Care Assessments, but also enjoined the hospitals from collecting the assessments from the participants directly, notwithstanding express contracts obliging them to pay whatever portion of the hospital's bill that was not paid by the insurer. 846 F. Supp. at 199-200. This unwarranted preemption of common law rights is more than an analytical tool, but has become a reality in Connecticut.

common law and its statutory embodiment. Nor can there be a difference, if "common sense" illuminates Congressional intent, that the "reasonable value" is legislatively determined pursuant to a detailed statutory reimbursement formula rather than by a judge on an *ad hoc* basis.

New York's reimbursement system, unlike the common law, precludes enforcement of express contracts to pay a negotiated rate (except in the case of HMOs). The statute limits the hospital's right to receive more, and the patient's right to pay less, than the established rate. The result is similar to that obtaining under *quantum meruit*, where a court fixes the maximum and minimum payment at the reasonable value based on costs.[7] Does ERISA preempt either (or both) of these limitations?

1. *Maximum Charges*

In discharge of its Constitutional duty to enact laws that protect and promote "the health of the inhabitants of the State" (N.Y. Const., Art. XVII, § 3), the New York State Legislature has engaged in the most extensive regulation of hospitals, specifying permitted, mandatory and/or prohibited activities, costs and charges in the fullest exercise of its police powers.

The regulation of hospitals' activities has among its goals the control of costs so as to make health care affordable. States' efforts to control rising health care costs is a national phenomenon, and "the regulation of public health and the cost of medical care are virtual paradigms of matters traditionally within the

[7] New York's statutory reimbursement formula takes a fundamentally different approach. In an effort to coerce hospitals to reduce and control costs, the prospective rate represents what the State determines the services *should* cost, and the actual or reasonable costs incurred are only tangentially implicated. If hospitals incur costs higher than the prospective rate, they are financially penalized; if below, they are rewarded for their efficiency. Beyond these incentives, the State regulates what costs hospitals are permitted to incur: the capital costs of an unauthorized MRI machine are not reimbursable.

police powers of the state." *Medical Soc'y v. Cuomo*, 976 F.2d 812, 816 (2d Cir. 1992), citing *Hillsborough County v. Automated Medical Lab. Inc.*, 471 U.S. 701, 719 (1985). Cost control results in the establishment of the *maximum* amounts hospitals can charge. Hospitals in a strong bargaining position cannot insist on more. Does ERISA preempt such state limitations on what hospitals can charge?

It is no answer, for ERISA preemption purposes, that a state law benefits, rather than burdens, a Plan. *All* state laws that "relate to" a plan are preempted, "even including state laws that are consistent with ERISA's substantive requirements." *Metropolitan Life Ins. Co. v. Massachusetts*, *supra*, 471 U.S. at 739; *see Mackey v. Lanier Collection Agency & Serv., Inc.*, *supra*, 486 U.S. at 829 (statute that exempted ERISA Plans from garnishment "to help effectuate ERISA's underlying purposes" held preempted).

The only argument that can be made in support of preemption of state limitations on charges is that Congress intended to preempt broadly. But if there must also be an "unmistakable" Congressional intent to intrude on the states' police powers (*Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981)), and "relate to" must be given its "common sense" meaning (*Pilot Life Ins. Co. v. Dedeaux*, *supra*, 481 U.S. at 47), then it is impossible to conclude that Congress actually intended to preclude state *limitations* on hospital charges. Not only would such a result not bolster Congress's purpose in enacting ERISA, it is diametrically opposed to decades of Congressional action encouraging state control of health care costs (see pp. 21-23, *infra*).

2. *Minimum Charges*

The affordability of health care is but one goal of state regulation. Access to quality health care is another. Also in the exercise of its police powers, a state attempts to assure access to and the delivery of quality care by precluding payment of less than the established rate. Hospitals must be financially viable to provide quality care and meet the niagara of regulatory mandates

imposed on them — from emergency care to staffing levels to infectious waste disposal. Can a state forbid express contracts to pay *less* than the reasonable value of the services or some other amount that reflects the state's judgment of what is a necessary payment to make quality health care accessible and affordable? Can a state protect those hospitals that are without competitive bargaining power from being coerced into accepting less than may be necessary to fund their operations?[8]

If a state, without offending ERISA, can establish maximums that hospitals may charge, then it must be that it can fix minimums that patients must pay. Wherever the line is to be drawn between what does and does not "relate to" an ERISA Plan, there is no evidence of a Congressional intent to place it between a state's power to establish a ceiling and its power to prescribe a floor.[9]

If there is no preemption of "run-of-the-mill" state law causes of action to enforce implied or express contracts (see p. 9, *supra*), there is no preemption of state hospital rate-setting statutes. Both the common law and statutory rights would "relate to" and have a "connection with" an ERISA Plan in like measure. Enforcement of the maximum/minimum charge established by a state's judges or its legislators equally serves or disserves *Congress's purpose* in enacting ERISA.

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[8] All hospitals are economically compelled to maximize occupancy so as to cover their fixed costs, which approximate 80% of their total costs. Many hospitals could not survive in a competitive environment because of their enormous and disproportionate costs in providing care to the uninsured poor, running teaching programs for interns and residents, and capital expenditures to replace aging plant and equipment.

[9] If, somehow, only the State's minimum charge were preempted, presumably the maximum would have to increase so as to offset the loss of revenue and permit the hospital to survive. New York's hospital rate regulation is not only comprehensive but integrated: the ceilings depend on the floors. The freedom of some plans with substantial bargaining power to pay less at the expense of other plans would seem to be an obscure objective of the ERISA legislation.

C. The Indirect Economic Impact of State Rate-Setting Systems Is Alone Insufficient to Result in Preemption

The Second Circuit held the New York differentials preempted because (i) they forced plans to either increase costs or reduce benefits "and this substantial economic impact could be enough to result in preemption," and (ii) they purposely interfere with the choices that ERISA plans make for health coverage. 14 F.3d at 719-21. Putting aside the specific differentials for the moment (see Point III, *infra*), the proposition that the indirect economic impact of a state rate-setting system is sufficient to trigger preemption is insupportable, unsupported by any decision of this Court, and plainly contrary to Congressional intent.[10]

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[10] After summarizing the general ERISA preemption jurisprudence established by this Court, the Second Circuit did not rely, directly or by analogy, on any decision of this Court as support for its conclusion. Instead, it relied on a series of lower court cases that provide no support for the proposition that an indirect economic impact alone is sufficient to preempt. In each case, a tax or other legal obligation was imposed directly on the plan. *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, _ U.S. _, 112 S. Ct. 585 (1991) (tax imposed on administrative fees directly based on benefits paid by ERISA plan; plan itself liable if administrator does not pay; specific Congressional intent found to preempt state taxes on plans); *National Carriers Conf. v. Heffernan*, 440 F. Supp. 1280 (D. Conn. 1977) (tax on plan benefits paid out); *Morgan Guaranty Trust Co. v. Tax Appeals Tribunal of Dep't of Tax. & Finance*, 80 N.Y.2d 44, 587 N.Y.S.2d 252 (1992) (direct gains tax on sale of ERISA property); *National Elevator Indus., Inc. v. Calhoun*, 957 F.2d 1555 (10th Cir.), *cert. denied*, _ U.S. _, 113 S. Ct. 406 (1992) (minimum wage law uniquely affecting plans, imposing requirements directly on plans and favoring one plan over another); *In Re Michigan Carpenters Counsel Health & Welfare Fund*, 933 F.2d 376 (6th Cir.), *cert. denied*, _ U.S._, 112 S. Ct. 585 (1991) (corporate reorganization law allowing employers unilaterally to alter their obligations to plans in direct conflict with ERISA's substantive provisions); *General Electric Co. v. New York State Dep't of Labor*, 891 F.2d 25 (2d Cir. 1989) (law mandating employers to pay particular benefits).

1. *Indirect Economic Impact, National Uniformity, and Administrative Burdens*

As *Fort Halifax* concluded, Congress's purpose was to exempt plans from a conflicting patchwork of inconsistent state regulations that would impose increased administrative costs and burdens upon plans. (See p. 6, *supra*.)

Lack of uniformity in the costs of hospital services is, of course, an immutable fact of life. There is variation nationally: some state systems are cost-based; some are charge-based; some are prospective and based on DRGs; and in some states rates are completely unregulated. Medicaid and Medicare have different systems that recognize geographic differences. Within a state, hospitals' charges and rates differ, depending on a wide variety of factors. Within a hospital, each patient will be charged differently in accordance with the kind and extent of the services rendered.

In the absence of any state rate regulation, uniformity in the costs of doing business — if, indeed, that were a goal of ERISA — would still be unattainable: the hospitals' self-determined charges, or as established on a *quantum meruit* basis, will produce disparate results across state lines and within a state. And the administrative burden upon a plan of paying different prices for each of its participants' hospital bills is unavoidable and slight: a different amount is entered on each check issued.

In *United Wire* (995 F.2d at 1194), the Third Circuit agreed with *Rebaldo*'s conclusion that there "is no valid reason why employee benefit plans cannot be subject to national uniformity despite dissimilarities in their costs of doing business," and that in the absence of state regulation rates will still not be "uniform, even as between hospitals in the same locality." 749 F.2d at 139.

It cannot seriously be contended that lack of uniformity and the administrative burdens that result therefrom are sufficient to preempt a state's rate-setting system. Indeed, that was not the basis for the decision below. Rather, the Court below based its decision on the relationship between price and plan benefits.

2. *Indirect Economic Impact and Plan Benefits*

State-regulated hospital rates have a "connection with" commercially insured ERISA plans as follows: patients are charged (and are liable for) the established price; the plan assumes, through its insurer, whatever portion of the patient's liability it chooses; increases in hospital prices may lead to increased insurance premiums; the greater a plan's costs, the fewer benefits may be available unless the employer increases funding. This connects with plans in "too tenuous, remote or peripheral a manner" to result in preemption. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983).

First, while ERISA preempts laws relating to "plans" and not "benefits," it is now established that states may not prescribe the *types* of benefits that plans must pay. (See p. 6, *supra*.) But this Court has never held that a law is preempted simply because it affects the price of benefits — as does a state-reimbursement system — and thereby may influence a plan's decision as to *its* selection of benefits and the extent of coverage.

Second, if the indirect economic impact of state-mandated rates is enough to preempt, then the common law remedies to enforce an unregulated price must fall as well: requiring the patient to pay *anything* will have a substantial economic impact; exemption from liability or prepayment before services is the only solution (p. 11, *supra*).

Third, if indirect economic impact is the test, the scope of preemption cannot be limited to regulation of hospital prices, but must also encompass all other state laws that increase, directly or indirectly, the plans' cost of doing business. In *United Wire* (995 F.2d at 1193-94), the Third Circuit quoted *Rebaldo*'s analysis as follows:

> "A preemption provision designed to prevent state interference with federal control of ERISA plans does not require the creation of a fully insulated legal world that excludes these plans from regulation of any purely local transaction.

* * *

The purchase of hospital service is like the purchase of public utility service, or of any other service or commodity whose price is controlled by the State. Insofar as the regulation of hospital rates affects a plan's cost of doing business, it also may be analogized to State labor laws that govern working conditions and labor costs, to rent control laws that determine what employee benefit plans pay or receive for rental property, and even to such minor costs as the Thruway, bridge and tunnel tolls that are charged to plans' officers or employees. In short, if ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress. Where, as here, a State statute of general application does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated."

See also Lane v. Goren, 743 F.2d 1337, 1340 (9th Cir. 1984) ("state laws and municipal ordinances regulating zoning, health, and safety increase the operational costs of ERISA trusts, but no one could seriously argue that they are preempted").

Rebaldo's observations are self-evidently true and remain "good law," notwithstanding that a different portion of its analysis was later rejected by this Court.[11] If economic impact is

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[11] *Rebaldo* concluded that, on the basis of ERISA § 514 (c)(2), a state law must "purport to regulate" a plan to be preempted. This interpretation was rejected in *Ingersoll-Rand Co. v. McClendon*, *supra*, 498 U.S. at 484. *United Wire* concluded that *Rebaldo*'s reasoning otherwise "remains persuasive," and would have been decided the same way post-*Ingersoll-Rand*. 995 F.2d at 1194. In the instant case, the Second Circuit disagreed, erroneously finding that its "fundamental premise" was undermined and

(Footnote continued)

the preemptive trigger, there is no end to the laws that must fall. Beyond direct state regulation of hospital *rates*, there are innumerable state laws that result in increased hospital *costs* that must be passed on to patients — minimum staffing requirements, adherence to sanitary standards, and the like. As *United Wire* observed, state regulation of the disposal of medical wastes "can significantly increase a hospital's cost of doing business and, accordingly, its billing to plan participants." The Court nevertheless concluded that "ERISA was not intended to foreclose a state regulation of this kind." 995 F.2d at 1196.[12]

Similarly, because laws that give an advantage to plans are equally subject to preemption (*Mackey*, *supra*, 486 U.S. at 829), the "economic impact" of state laws *limiting* rates or even hospitals' costs — *e.g.*, disallowing reimbursement for an unauthorized MRI machine — would also be unlawful. After all, as the logic of the "economic impact" theory goes, the lower hospital costs might enable a plan to *increase* the level of benefits to its participants.

Nor, if the test for preemption is economic impact, can the inquiry logically be confined to those laws that influence the price of what plans purchase. An equal impact on the plan results from those generally applicable state laws that affect contributions to plans. Taxes, environmental compliance requirements, safety standards, and the like, all have a strong impact on employers' profits and derivatively on contributions

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"its analysis is poisoned by its discredited belief" that a law must "purport to" regulate plans.

[12] Indicative of the Second Circuit's view of ERISA preemption and the scope of the instant decision, is that Court's recent Opinion in *NYSA-ILA Medical & Clinic Serv. Fund v. Axelrod*, 27 F.3d 823 (2d Cir. 1994). The Court there invalidated New York's 0.6% tax on the gross receipts of all health care facilities because it was applied to two facilities that were owned and operated by ERISA plans. If "economic impact" alone were sufficient to preempt, it would follow that these facilities would be exempt from costly requirements, for example, that only licensed physicians could perform surgery.

that they can and/or will make to fund their plans. *Rebaldo* spoke to such laws as directly applied to plans, but the same economic impact influences plan benefits when consideration is given to contributions by employers — or even by employees.

In *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987), a municipal income tax was challenged to the extent that employees' contributions to ERISA plans were made subject to the tax. The Court rejected the claim that the tax's influence on employees' contribution decisions required preemption. It concluded that the tax "affects Firestone employees in their capacity as employees, without regard to their status as participants in an ERISA plan," and any effect on plans is incidental and remote. *Id.* at 556. The Second Circuit's economic impact rationale would apparently dictate a different result.

The statute itself provides helpful guidance in discerning Congress's intent as to the preemption of laws solely on the basis of their indirect economic impact on plans. In 1983, Congress amended ERISA so as to exempt portions of Hawaii's Prepaid Health Care Act, but made clear that this exemption did not shield state tax laws from preemption. The amendment provided that nothing in the Hawaii exemption shall be construed to exempt from the general § 514(a) preemption provision "any State tax law *relating to* employee benefit plans." § 514(b)(5)(B)(i) (emphasis added) [29 U.S.C. § 1144(b)(5)(B)(i)].

Assuming that "relating to" in § 514(b) has the same meaning as "relate to" in § 514(a); that Congress intended to preempt equally expansively with respect to "laws" and "any State tax law"; and that Congress *did not* intend to preempt state income taxes on employers or employees, notwithstanding their indirect economic effect on plans — it is therefore difficult to see how state laws that affect the price of what plans purchase are preempted. Tax laws affect employers and employees without regard to their status as plan sponsors or participants. Rate-setting laws affect patients (and derivatively their plan or non-plan insurers) in their capacity as patients without regard to

their participation. Both costs and revenues may affect plan benefit levels, and the economic impact of state laws on each side of the ledger has an equal — and equally tenuous — connection with plans.

The problem that inheres in finding indirect economic impact, standing alone, a sufficient "connection with" plans to warrant preemption is that there is essentially no limit to state laws that impact — positively or negatively — on plans' costs of doing business or contributions to plans. Difficulties of application aside, such a test for preemption has never been adopted by this Court and was never intended by Congress. The economic impact of a state law — even a substantial economic impact — without more, is insufficient to preempt, just as this Court held in *Mackey*, *supra*, 486 U.S. at 832. In the case of a state hospital rate reimbursement system there is no more.

D. Congress Did Not Intend to Limit States' Control of Hospital Costs and Rates

That Congress intended to preempt broadly in connection with ERISA plans is not the end of analysis, because Congress *also* intended to accord states wide latitude and flexibility in devising reimbursement systems so as to control and equitably apportion the costs of health care.

Rebaldo examined at length Congressional intent with respect to both subjects (749 F.2d at 135-38), but the Court below did not. If the quest is to discern an "unmistakable" Congressional intent to preempt (*Alessi*, *supra*, 451 U.S. at 522), that examination cannot ignore 25 years of Congressional encouragement of state cost control and rate-setting systems. And such a review precludes the conclusion that Congress actually intended to preempt state rate-setting systems that establish the rates paid by plan participants. The broadest reading of "relate to," the most expansive view of "connection with," and the fullest appreciation of the effect of "economic impact," cannot lead to that conclusion.

If Congress intended to preclude states from regulating hospital rates for nongovernmental payors, then Congress has repeatedly wasted its time in 1967, 1980, 1983, and 1990 conducting hearings, writing reports, and enacting provisions concerning the authority of the Secretary of Health and Human Services to waive federal Medicare requirements so as to allow Medicare payments to be set by state reimbursement systems. If such state reimbursement systems became unlawful in 1974 with the enactment of ERISA, it is impossible to explain why Congress would continue thereafter to refine the waiver authority in minute detail.

As more fully shown in the Brief of Petitioner Hospital Association of New York State (to which we respectfully refer the Court), Congress recognized that all-payor systems served to control costs, first encouraging and later mandating the Secretary to include Medicare in such systems upon a state's request. Indeed, New York's all-payor system was itself reviewed in 1983 in connection with an expansion of the Secretary's authority. Moreover, it is impossible to reconcile a supposed Congressional intent to preempt states' rate-setting power with its enactment of a "Special Rule" that specifically approved New York's uncompensated care reimbursement system — pursuant to which *all* payors were required to contribute — as satisfying the Medicaid "disproportionate share" requirement. 42 U.S.C. § 1396r-4[e].

In light of Congress's specific approval of New York's requirement that *all* payors share in the costs of uncompensated care, it simply cannot be that Congress intended, *sub silentio*, to exempt ERISA participants and their insurers from participation. It cannot be that Congress's 25-year review and modification of the Secretary's authority to participate in state all-payor reimbursement systems was an exercise in futility because Congress intended all-payor systems to be unlawful. Congress's extensive post-ERISA initiatives for state all-payor rate-setting systems

make it impossible to conclude that it intended to preempt state hospital rate-setting.[13]

III

ERISA DOES NOT PREEMPT A STATE'S POWER TO ESTABLISH DISPARATE HOSPITAL RATES

If state laws that establish mandatory and *uniform* hospital rates for patients do not have a sufficient connection with an ERISA plan to result in preemption, does a system with *disparate* rates somehow cross the line? Such disparate rates result from the application of the differentials here at issue. Unlike the 11% and 9% differentials (as to which amici take no position), the revenue generated by the 13% differential is retained by the New York hospitals and applied to meet their costs of operation.

A. Disparate Rates and the Goals of State Rate-Setting

As noted above, the basic goal of state rate-setting is to assure access to quality health care at a reasonable cost for all of the state's inhabitants. States must retain regulatory flexibility in devising reimbursement systems that will not only control costs, but will produce sufficient revenue for hospitals that are required to meet ever-increasing demands for medically intensive and

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[13] Beyond evidence of a Congressional intent not to preempt a state's rate-setting power, the Secretary's waiver authority would save an all-payor system from preemption by virtue of ERISA § 514(d), which provides that no ERISA provision shall "impair or supersede any law of the United States." Judge Van Graafeila correctly concluded in *Rebaldo*, 749 F.2d at 139-40, that a finding of preemption would impair the Secretary's authority. (The remainder of the Court took no position on the issue.) The point is that if states' rate-setting power is preempted, if "all-payor" systems cannot lawfully exist, there is no system that the Secretary could choose to adopt in lieu of standard Medicare reimbursement principles. The authority to waive becomes a fiction. The concept of impairment is certainly broad enough to encompass nullification.

expensive services for a growing geriatric population, for AIDS and TB patients, and for drug abusers and their victims.

In the absence of state regulation, a hospital's self-determined charges will be set to attempt to generate sufficient revenue to meet its needs. Whatever costs are unmet by virtue of inadequate Medicare and Medicaid rates, and by serving the uninsured, they will be shifted to paying patients — at least by those hospitals with a strong competitive bargaining position. The lack of a strong incentive to control costs by such hospitals was a principal basis for Congress's encouragement of all-payor systems. For many hospitals that serve a high volume of Medicaid and uninsured patients, such as urban hospitals, cost-shifting is not a realistic alternative funding source. Without state regulation, their continued existence would be threatened and the goal of access to quality care for all citizens would be undermined.[14]

The history and purpose of the 13% differential are fully described in Petitioners' Briefs and demonstrate that the provision of lower rates for Blue Cross patients is an appropriate exercise of the State's power to establish rates generally because the differential touches upon the goals of both cost control and access. As to cost control, the initial purpose of the 13% differential was to *limit* and make uniform the shifting of costs to commercially insured patients, and to recognize the Blues' prepayments to hospitals for working capital. As to access, the financial stability of the Blues is essential to produce sufficient hospital revenues: without such coverage of otherwise

[14] In *New England Health Care, supra*, 846 F. Supp. at 196 n.9, the District Court invalidated Connecticut's Uncompensated Care Assessments and observed that, without state rate-setting, ERISA plans would be free to encourage their participants to avoid urban hospitals that incurred relatively large uncompensated care costs. It seems unlikely that the destruction of hospitals that principally serve the poor was Congress's intent in preempting state laws that relate to plans.

uninsurable patients, hospitals' uncompensated care would rise dramatically.

By establishing lower rates for the Blues (and continuing the historic discount), New York has made appropriate provision for the higher costs incurred by the Blues' high-risk and high-cost patients that result from the State-mandated open enrollment policy, has attempted to provide financial stability for this vital insurer so as to make affordable insurance available through the community rating requirement, and, in the process, has neither transgressed any legitimate ERISA concern, nor crossed the line between tenuous and proscribed state action.

In terms of the goals of rate-setting, New York's reimbursement system operates as a unified whole. The challenge here to the 13% differential is, however, highly selective: the commercial insurers seek to excise one tree from the forest of regulatory provisions while retaining the benefits of state control of hospital costs and permitted charges — here, the base DRG rate. But if, for ERISA preemption purposes, a state can lawfully establish uniform rates, there can be no difference when it sets disparate rates so as to generate sufficient hospital revenue to provide access to quality care. Cost control and access cannot be so easily separated by ritual incantations of the breadth of ERISA's preemptive sweep — particularly in light of Congress's recognition of payor differentials within all payor systems.

As shown in the Brief of Petitioner Hospital Association of New York State, Congress reviewed and specifically approved New York's all-payor reimbursement system in connection with the 1983 Medicare Amendments. *And that New York system did not provide for uniform rates*: Blue Cross received a discount of 12%-15% as compared to commercial insurers. N.Y. Pub. Health L. § 2808-c(1) & (6).

B. The Differentials Do Not Relate to ERISA Plans

1. *"Reference To" and "Depend Upon"*

The patients subject to the 13% differential include:

> "patients eligible for payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law, the volunteer ambulance workers' benefit law or the comprehensive motor vehicle insurance reparations act; or enrolled in a self-insured fund which provides for reimbursement directly to general hospitals on an expense incurred basis, . . . or insured under a commercial insurer licensed to do business in this state and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on an expense incurred basis, and the insurer makes payments directly to the general hospital . . . ." [N.Y. Pub. Health L. § 2807-c(1)(b)].

The statute, on its face, does not refer to an ERISA plan or accord different treatment to plan participants in the same category as nonparticipants. Nor does the statute in its operation accord different treatment: commercially insured patients are liable for, and the insurer will pay, 113% of the DRG rate, regardless of their participation in an ERISA plan. Patients with Blue Cross or HMO coverage will not pay the differentials, regardless of their participation.

The result of the Decision below is to require different treatment: those patients eligible for benefits, for example, under the workers' compensation law and who are plan participants will pay *less* than similarly eligible nonparticipants. Congress did not intend to confer such a "charmed existence" on these patients.[15]

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[15] Ironically, if the New York statute *expressly incorporated* the result below — "all ERISA plan participants are exempt from the differentials" *(Footnote continued)*

Accordingly, the statute does not depend upon the existence of an ERISA plan for its operation. That conclusion is not altered by the fact that many plans are commercially insured or that it is anticipated or desired that plans might choose to switch coverage. In that connection, the Third Circuit observed in *United Wire, supra*, 995 F.2d at 1192 n.6, that it disagreed

> "that a statute should be preempted solely because the participation of ERISA plans is required as a matter of economics in order for the statute to meet its social goals. This is not what we understand the Supreme Court to have meant in *Greater Washington Board of Trade* when it held that statutes predicated on the existence of ERISA plans 'relate to' such plans. The statute in that case could not be applied without reference to the 'coverage levels set forth in ERISA plans.' As we understand it, it is of no legal consequence if removing ERISA plans from the scene would diminish the likelihood that the statute would meet its social goals. Rather, the test for preemption in this regard is whether the existence of ERISA plans is necessary for the statute to be meaningfully applied. *Greater Washington Board of Trade*, _ U.S. at _, 113 S. Ct. at 583-84."

If the New York statute is found to depend upon the existence of an ERISA plan, difficult questions arise in terms of future application of such a standard. Does preemption hinge upon the market share of Blue Cross vs. commercial insurance?

— it would be preempted because it referred to an ERISA plan. *Mackey, supra*. The result would be that plan participants would have to pay the *same* rate as other commercially insured patients who are not participants. But the statute's silence as to ERISA participation does not save it from preemption, according to the Court below, because the only lawful result is, indeed, that participants pay less than nonparticipants. And, implicitly, the only way to accomplish that is to have the result published in F.3d rather than in McKinney's New York Statutes. This is the necessary consequence of the ruling below.

That is to say, if 90% of all ERISA plans within a state had chosen the Blues for coverage — and benefitted from its lower rates — would the differential be barred because 10% of the plans elected commercial insurance with higher rates? Would the preemption consequences differ from state to state depending on market share? The point is that the differentials may make commercial insurance companies unhappy, but they do not restrict a plan's freedom of choice as to coverage, much less its choice of the type of benefits offered.[16]

2. *Structure, Administration and Economic Impact*

Ignoring the discrimination that its holding produces within the category of patients subject to the differential, the Second Circuit focussed instead on the differences between commercial rates and Blue Cross rates. It held that because the differential increased the costs of commercial insurance and made such insurance less competitive with the Blues, an ERISA plan's health care benefits and its choices of coverage are purposely interfered with. Accordingly, it held that the "indirect economic impact upon ERISA plans was substantial and impermissibly affected the structure, the administration, or the type of benefits furnished by a plan." 14 F.3d at 708. This analysis and its conclusion are unsustainable for several reasons.

To the extent the reference to "structure" and "administration" of plans means to reflect a concern for administrative burdens flowing from lack of national uniformity, no such

[16] Elimination of the differential will effectively force the State to provide for uniform rates (if that power is not preempted), but the need to provide sufficient revenue to the hospitals could well lead to an increase in the Blue Cross rate. ERISA plans that have chosen such lower-cost coverage will be disadvantaged. If, as the Second Circuit concluded, making Blue Cross coverage more attractive is preempted, would a new law making such coverage relatively less attractive similarly be preempted? After all, plans with Blue Cross coverage will face increased costs, which might result in a reduction of benefits.

burdens result from the differentials and national uniformity is not an issue. There are no differences in this regard between state rate-setting statutes that mandate uniform rates and those that produce disparate rates. (See p. 16, *supra*.)

Similarly, if economic impact is insufficient to preempt mandatory uniform rates, it is insufficient to preempt disparate rates. (See pp. 17-21, *supra*.) It cannot make a difference, for ERISA preemption purposes, that a hospital bill is $1,000 or $1,130. Both bills — among countless other factors determining price — may affect a plan's choice as to the level of benefits it will provide, but how either price affects "the *type* of benefits furnished by a plan" (14 F.3d at 708, emphasis added) is a mystery.

The commercial insurers have asserted that the higher costs imposed upon them by virtue of the differentials will cause them to pass such costs onto ERISA plans. *Id.* at 720. But wholly apart from the many factors that establish hospital prices, and the many choices that plans have for their insurance coverage,[17] there are countless state laws that impose requirements upon commercial insurers — if that is the plan's choice — and affect the premiums they charge. It would appear to be difficult to distinguish between the differentials (which favor the Blues) and state income taxes (from which the nonprofit Blues are exempt) in terms of the economic impact on commercial insurers and derivative impact on plans that choose commercial insurance for coverage. Both laws create costs that may be passed on to plans (and non-plan insureds) and, it can be argued with equal fervor,

[17] Plans may insure with Blue Cross at the DRG rate, obtain commercial insurance at 113% of the DRG rate (or 111% for prompt payment), insure through an HMO which pays either a negotiated rate or 113% of the DRG rate, self-insure and pay either 113% of the DRG rate for direct payment or hospital charges (higher or lower than the DRG rate) for indirect payment. N.Y. Pub. Health L. § 2807-c(11)(e).

that plan benefits may thereby be reduced.[18] If the "connection with" such income taxes and plans is too tenuous to trigger preemption, so too is the case of the differentials.

Conclusion

In the end, if the states' power to establish mandatory hospital rates, including disparate rates, is preempted, if the Second Circuit's analysis is correct, the issue before the courts would no longer be whether a law "relates to" an ERISA plan, but whether there is any state law that does not.

However broadly Congress intended to preempt state laws that interfered with the efficient operations and choices of ERISA plans, it did not mean to restrict states in their efforts to provide full and equal access to health care services for all of their inhabitants through the equitable regulation and apportionment of hospital costs. And it did not intend the result below.

For all of the foregoing reasons, the American Hospital Association, the Maryland Hospital Association, Inc., and the Massachusetts Hospital Association, Inc., as Friends of the Court, respectfully urge this Court to reverse the decision of the Second Circuit Court of Appeals.

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[18] As noted above (p. 15n), the Second Circuit relied on several lower court decisions holding state tax laws that directly applied to plan operations or income to be preempted. Whatever the validity of those cases, state tax laws imposed on commercial insurers are one step removed and the connection is one step more tenuous. The differentials, reflected in bills to patients that may or may not be covered by commercial insurance, are two steps more tenuous.

Dated: November 16, 1994

Respectfully submitted,

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